VOLUNTARY FINANCIAL SUPPORT AGREEMENT

Person's Name	**Person's Street Address**
Guardian's Name (if applicable)	**Person's City, State and Zip Code**

I the above mentioned person, voluntarily request financial support from the Department of Human Services, Division of Services for People with Disabilities or a provider under contract with the Division. I have discussed possible benefits, disruptions, intrusions, alternatives to service, and requirements for continued services, and agree to the conditions thereof. I have been made aware of my rights and responsibilities in receiving financial supports, and the Department of Human Services' authority and responsibilities in providing the requested services.

The financial support I will receive will involve management of income and resources from ❑all sources ❑SSI ❑SSA ❑employment ❑other (please specify)_____

_____

_____

_____

This agreement will become effective: this_____day of _____, 200_ , and will continue until: (choose a or b)

❑ a. the_____day of _____, 200__, or

❑ b. until services are no longer deemed necessary by myself and/or the Department of Human Services.

I understand that this is not a legally binding document, and that the sole purpose is to identify the voluntary arrangement of services.

Person's Signature Date

_____ _____

Guardian's Signature Date

_____ _____

Division/Provider Staff Signature Date

_____ _____